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WELCOME TO OUR FALL/WINTER 2018 ISSUE!
Telemedicine has been called the Next Big Thing in medicine (though our Chief Medical Officer recalls seeing telemedicine in action back in her childhood, as she shares in this issue’s “Meditations on Medicine” column).

There’s no doubt that ever-greater connectivity, the ubiquity of devices already in our patients’ and our own lives, and the potential of telemedicine to make inroads on problems—from access challenges to diagnostic error—is driving huge interest in this area. In one industry report, 90 percent of executives surveyed reported that their organizations have already begun developing or implementing a telemedicine program.¹

Along with increased interest and uptake in telemedicine programs come more questions and risks. In our Telemedicine issue of Brink, we explore both the possibilities and the perils of medicine at a distance. We hope to leave you better informed, more aware of what to watch for, and more confident in pursuing this promising path.

- We provide a broad overview of developments in telemedicine and delve into whether this fast-evolving means of providing care is creating new standards of care. Check out our “Telemedicine Risk Checklist” on page 17.
- We visit our coverage territory, showing how a sparsely populated state in the West was inspired by necessity to make big inroads in telemedicine…and how three Midwestern health systems have expanded their services to patients using telemedicine.
- And, of course, we alert readers to make sure they understand their professional liability coverage for the services they provide via telemedicine—see page 21.

For an exhilarating taste of the future in store for telemedicine, check out the last few chapters of “Digital Medicine” by Robert Wachter, a book we review in this issue.

Many of you joined us over the summer at educational programs where our patient safety and risk management experts presented on “Evolving Models of Care: Eight Questions to Ask Before Diving into Telemedicine.” If you weren’t able to attend, we invite you to join us online on January 10, when we’ll deliver a webinar on the same topic.

As always, we welcome your feedback on this issue and encourage you to reach out if we can help you in any way.

All my best,

Bill McDonough
President and CEO, Constellation

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RX FOR ELIMINATING VENDOR VISITS

On February 15, Lynne Evans, UMIA Senior Risk and Patient Safety Consultant, will present the webinar, “Prescribing Practices: Eliminating Vendor Visits and Samples in the Outpatient Setting.”

Pharmaceutical companies spend billions each year marketing to physicians, resulting in the inappropriate prescription of brand-name drugs in place of safer alternatives. Studies repeatedly demonstrate that even small gifts negatively influence prescribing, including decreased prescribing of generics, increased costs and potentially adverse outcomes. Accepting gifts violates ethical principles and increases risk.

Risk managers are in a unique position to instigate change and work with medical staff to ensure that industry-physician relationships are both ethical and legal. This webinar will guide risk managers through the process of eliminating vendor visits and gifts in the outpatient setting.

NEW! Physician Empowerment Suite now includes a new continuing education credit for AMA PRA Category 1 and MOC credit(s) to providers nationwide.

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Telemedicine:
Some Terms & Definitions

The rapid evolution of telemedicine in the twenty-first century continues to introduce exciting opportunities for increased access to care for underserved patients. But as with many technologies, the rapidity of its introduction presents an environment of new and unknown risks.

In this issue of Brink, focused on telemedicine, we strive to present our risk expertise with current standard of care best practices, as well as salient questions on areas in which the answers are still being worked out.

We understand that various entities are using the terms telemedicine and telehealth differently, sometimes interchangeably. For clarity, we would like to provide a definition of telemedicine as presented within this issue.

Simply stated, telemedicine is the remote delivery of clinical care to a patient by a health care provider. Such technology may include telephonic systems, audio/video conferencing, and other internet-based communications. A telemedicine encounter may be initiated in various ways. For example, a physician assistant may engage a remote specialist on behalf of a patient during a hospital stay; or a patient at home may directly engage a remote provider from a computer and webcam by appointment.

Telehealth further broadens the scope of telemedicine by including non-clinical services, such as virtual education and patient portals.

~Brink editorial team

Telemedicine:
Some Terms & Definitions

Type of telemedicine by originating/distant site

Provider to provider
(a.k.a. hub and spoke)
Reimbursed by private insurance on a state-by-state basis

In this Issue:
Inside a Midwestern Telemedicine Hub, p. 10
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Montana Embraces Telemedicine, p. 18

Provider to patient
(a.k.a. direct to patient)
Reimbursed by private insurance on a state-by-state basis

In this Issue:
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Direct to consumer
Not reimbursed by private insurance, but sometimes offered as an employee benefit

In this Issue:
A Prescription for What Ails Health Care?, p. 6
Examples of direct-to-consumer apps (not mentioned by name in this issue) include Amwell, Teladoc, and Doctor on Demand
**telemedicine** (noun)

the remote delivery of clinical care to a patient by a health care provider

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1 in 5

people would switch to a doctor who offered a video visit option

85%

of 1,557 physicians in a 2015 survey said they would consider using telehealth if they were ensured reimbursement

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**Telemedicine: Past, present and future**

1989

MedPhone Corp. launches first phone-based technology platform enabling telemedicine providers to remotely diagnose and treat patients requiring cardiac resuscitation.

1997

Medicare provides reimbursement for telemedicine consultations for patients living in “rural health professional shortage areas.”

2008

The number of adults in the United States using the internet reaches 75%.

2009

The American Recovery and Reinvestment Act includes $7.2 billion to improve broadband internet across the nation, intended in part for access to health care.

2010

Accountable Care Organizations (ACOs) created to push for the maturation of telehealth capabilities.

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“The innovation that telemedicine promises is not just doing the same thing remotely, but awakening us to the many things that we thought required face-to-face contact but actually do not.”

—David A. Asch, MD

Leading Medical Services Using Telemedicine

- Radiology
- Mental Health
- Pathology
- Primary and Urgent Care
- Intensive Care
- Unit Monitoring
- Chronic Care Monitoring

Telemedicine was the top regulatory issue of 2016, according to a survey of U.S. state medical and osteopathic boards by the Federation of State Medical Boards.3

59% of large employers offered telemedicine in 20165

90% of 133 large companies surveyed in 2016 said they expect to make some telemedicine services available to their workers in 20176

2012
42% of acute care hospitals have telehealth capabilities.12

2014
The federal government provides $22.1 million to improve access to health care in rural areas.13

2017
The AMA approves new ethical guidelines for telemedicine.14

... President Trump declares the opioid epidemic a national public health emergency, allowing for expanded access to telemedicine services, including remote prescribing of medicine used for substance abuse or mental health treatment.15

2020
Hospital implementation of telemedicine technology is projected to reach 53%.16

2030
Physician shortages are projected to reach between 40,800 and 104,900 across the United States. Telemedicine to reach underserved patient populations is identified as part of the solution.17

Telemedicine: A Prescription for What Ails Health Care?

Exploring the world of telemedicine today.

Interview by Anne Geske
Current and near-future health care trends point to physician shortages, a changing American demographic (older and sicker), and lack of access to primary, emergent and specialist care—not to mention a lack of access to affordable health insurance.

Telemedicine, an evolving health care delivery method, is being touted as having the potential to go a long way toward solving physician shortages and cost issues. Can it be everything to all patients? Or does it come with certain risks?

We talked to Dr. Elizabeth Krupinski about these and other questions. Dr. Krupinski is the associate director of evaluation for the Arizona Telemedicine Program, co-director of the Southwest Telemedicine Resource Center, professor and vice chair for research in the Department of Radiology and Imaging Sciences at Emory University, and past president of the American Telemedicine Association.

**BRINK:** Is telemedicine, if we define it as the remote delivery of clinical care to a patient by a health care provider, a service line, a method of delivery, a care model?

**EK:** A lot of us in telemedicine like to refer to telemedicine simply as another tool that can be utilized to reach out and deliver care to patients who just happen to be at a distance. It’s not a separate clinical subspecialty or a different model per se. It’s simply using telecommunications technology (and other devices) to connect patients to providers in a way that telecommunications technology allows now that hasn’t been done in the past. In the past, patients would call their physicians and say, “My kid has this fever, they’re holding their ear all the time, what do I do?” Telemedicine simply offers a way to get more information utilizing an audio tool that just happens to be a computer instead of a phone, with video added. At the local site, the clinician might also have a typical tool such as an ENT scope that’s been used forever, but now it happens to have a digital connection so the clinician at the remote site can see the same thing that the local clinician is seeing. Telemedicine isn’t a different model in the sense of health care, but a different model in terms of delivery. A lot of us would rather see the “tele” part go away and just say: This is medicine—it’s simply another tool in our arsenal to deliver health care. Telemedicine is becoming more and more prominent, and it’s going to become the natural way of interacting with physicians and other health care providers.

**BRINK:** How is telemedicine being practiced today?

**EK:** It’s used in practically every clinical specialty and aspect of health care, by physicians, nurses, allied health professionals, dentists, rehab, speech pathology, language, psychiatry—you name it. How it’s used depends on the individual application area, local circumstances, resources available, and so on. The majority is conducted using what we call the real-time interactive mode—a consult using video connections. Some of it is store-and-forward, such as teleradiology, telepathology, telecardiology, and dermatology. There’s also remote monitoring, where patients are utilizing devices and collecting data that get transmitted to their physician remotely and get incorporated into diagnostic decisions. The tele-ICU is a sophisticated form of remote monitoring, where you have dedicated software and cameras in the local ICU, and a clinician at a remote location has access to all the real-time data from the ICU in order to monitor patient status, such as a small-town hospital that simply doesn’t have the capacity and personnel. That’s an incredibly useful and important model.

**BRINK:** How would you characterize the types of telemedicine by originating site (patient) and distant site (provider)?

**EK:** *Provider to provider* is the hub-and-spoke, or traditional model, with providers such as an MD, nurse, site coordinator. It’s the most accepted, or seen as most legitimate, and the most reimbursed. *Provider to patient* is the next level, such as use in telepsychiatry or post-surgery follow-up. Sometimes called direct to patient, this is where a patient is in their own home or work space seeing a provider with whom they have an established relationship (and therefore access to medical history and records). This type of telemedicine is also generally reimbursable. Then there is *direct to consumer*, which is basically a cold call. These aren’t brick-and-mortar hospitals or clinics, but online services that have recruited physicians to their “virtual” practice. Everything is done virtually. Patients go online and talk to a provider—could be by video, audio only, or even email. You connect with a provider you’ve likely never met before, they assess your problem, provide you with what you need to do and sometimes even prescribe. The difference between this and the provider to patient level is whether there was an existing relationship. Again, part of this is the provider’s access to records. Direct to consumer rarely if ever has such access, and is almost never reimbursable. The patient gives their credit card number—it’s not going through insurance. Increasingly, direct-to-consumer is being offered as an employee benefit, where the employer offering it will contract with a given service, thus using another payment model option.

**BRINK:** Is the increasing adoption of telemedicine poised to be an answer to physician shortages?

**EK:** I think it’s more of a maldistribution of clinicians than a shortage, per se. Everybody wants to live in the big city, and everybody wants to practice at or close to where the academic
medical centers are. To some extent, telemedicine is addressing shortages because it encourages providers to live in rural areas, to make that their lifestyle choice. Right now, a lot of the rural physicians are there for only a short period of time and then they cycle out. The ECHO telemedicine model, for example, can help by providing rural physicians with the support and connections they need to do their jobs. The ECHO model was developed at the University of New Mexico and is incredibly popular and actually endorsed by the government. With this model, physicians at a variety of sites, typically with an academic medical center being one, will connect for an hour or so with a group of different rural clinicians—usually primary care. They’ll spend half the time doing a didactic lecture, and then the second half is spent on the clinicians’ cases. The patients aren’t there, so they’re just describing cases. Physicians or clinicians maybe show a picture of, say, a dermatologic condition and tell what they did, then ask the expert what they would have done—they consult. This is a provider to provider model, but adding in the educational piece. This is getting reimbursed more and more, as well. With this model, there’s both education and support to rural physicians, making it easier for them to remain in these rural communities. Yes, there are shortages in some areas. But if we can get clinicians to want to live in rural communities, models like ECHO—and telemedicine in general—can help by providing the same level of patient care as if they were in the big city, and providing resources through telemedicine that in the past have not been available in the rural community.

**BRINK:** Will telemedicine be an answer to the high cost of health insurance?

**EK:** There have been a lot of studies showing the cost benefits of telemedicine—that it saves both patients and physicians travel time. Telemedicine interventions reduce the length of hospital stays and they reduce the number of trips to emergency rooms among other savings. The cost savings are for health care in general, as well as for insurance companies. Telemedicine is becoming more integrated into Medicare, Medicaid, and private insurance. At the big picture level, I think health care in the United States lost track of preventive care. It went by the wayside. What we have is a system where the majority of our health care money goes to a minority of patients with multiple chronic conditions, whereas the majority of people have relatively good health. They need insurance when something goes wrong, but the result is that people couldn’t afford health care because costs were so high due in part to these [sicker] populations, and therefore preventive and primary care became less affordable. What telemedicine can do, now and in the future, is get us back to preventive care—catching, diagnosing and treating conditions earlier—which in the long run is going to reduce health care costs.

**BRINK:** The risks we hear about—lack of hands-on care or follow-up, different doctor-patient relationship—are these real risks, or have they been largely debunked with the responsible practice of telemedicine?

**EK:** It’s an evolving model. Especially in the beginning, those were legitimate concerns and in some cases now they’re legitimate concerns as well. Some things cannot be done remotely. It’s the same thing as health care in general. There are certain things you should go to your primary care physician with, and there are some times when you should go straight to the emergency room. A lot of it is figuring out what the work flow is, figuring out what’s appropriate versus not appropriate. Poison control lines have been in existence for decades, and they’re highly appropriate—that’s a form of telemedicine right there. A parent calls the poison control line, and describes what happened over the phone and a decision is made with the expert on the phone to treat at home, take the child in to the emergency room, or call 911. In the beginning, all of those processes had to be worked through. In telemedicine, we simply have to assess and establish what the optimal work flows are, what the standard operating procedures are, and what’s appropriate and not appropriate. Each clinical specialty has to define what’s appropriate for telemedicine. I don’t think it can be done by the insurance companies or the government. Those in the field have to decide based on experience, technology, work flow, etc. As far as the direct to consumer model, though, there have been studies where the accuracy of the diagnosis is questionable. These clinicians do not have access to any patient records, which is part of the problem. Unless they know the right questions to ask, they could be missing some important information.

**BRINK:** What should physicians, clinicians, and administrators know about telemedicine and what it can do for their organizations?

**EK:** In order to do telemedicine, you have to figure out the where’s and the why’s before you do it. If it’s just because it’s cool and you want to jump on the bandwagon with everybody else, that’s the wrong reason. If you do a solid needs assessment, find out which clinical specialties, which patients are going to benefit from the service, how many patients, and so on—that should guide your decision to go into telemedicine. How is it best going to suit your organization? How are you going to integrate it into your work flow? I think integration is the main reason most telemedicine programs fail; they don’t integrate it properly, they don’t train people properly on how to use telemedicine. You don’t have to have some sort of degree or credential in telemedicine, but people need to be taught how to act in front of a computer monitor with a camera—how to do this type of consult. A good place to start is Telehealth Resource Centers. This is an organization of 14 telehealth resource centers across the country funded by the federal government (HRSA) in order to provide advice and information about telemedicine—how to implement rules, regulations, policies, training. We’re a resource for anyone getting into telemedicine.

**RESOURCE**
Telehealth Resource Centers. [https://www.telehealthresourcecenter.org/](https://www.telehealthresourcecenter.org/)

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**ANNE GESKE**
Health Care Feature Writer
Inside a Midwestern Telemedicine Hub

Avera connects clinicians to rural patients at the touch of a button.

By Liz Lacey-Gotz

It was a hot, summer day in Marty, SD, when a woman out with friends stumbled onto a deadly rattlesnake. Before she knew she’d been bitten, she was being transported to a community hospital. Anticipating her arrival, the rural hospital used high quality audio-visual equipment to connect with a telemedicine hub in Sioux Falls, 100 miles away. Within seconds, the remote emergency medicine team was ready. The patient entered the emergency room, and the local hospital team was bedside with the patient while the hub team worked bedside.

When the teams realized the patient was having an allergic reaction to the anti-venom serum, the hub physician was able to walk the local team through the procedure to quickly open the airway, using a special handheld camera that can look inside the throat and transfer images in real-time to the hub. With instruction, the local team was able to insert the camera, locate and visualize the vocal cords, then use a tube to open the airway. Just as the patient was losing her pulse and vital signs, the airway was opened and her life was saved.
This story is now among thousands from Avera eCARE, a telemedicine operation that began within the Avera Health System in 1993. Expanding its services over time, Avera eCARE moved to its own facility in 2012 and now offers services to 340 facilities in 14 states. Today, it offers ICU, pharmacy, emergency and senior care services, plus a specialty clinic that links rural patients to 100+ specialists via interactive two-way video technology.

**Team-based approach**
To keep it simple, and because South Dakota laws don’t allow reimbursement for the provider-to-provider, hub-and-spoke style of telemedicine, most of Avera’s eCARE services are provided on a subscription basis. It’s a team-based, collaborative model that encourages customers to use the services anytime they need them, without worrying about additional expenses. Subscribers push a button and are linked via audio-visual connection within five seconds.

According to Dr. Kelly Rhone, emergency medicine physician and Avera eCARE medical director for outreach and innovation, a team-based approach allows Avera to improve quality metrics and share the workload on an as-needed basis. “We are licensed and credentialed in each hospital we work with, so we are part of their team. This allows us not only to improve outcomes, but also help with work-life balance for the clients we serve.”

**A boon to rural patients—and physicians**
For rural patients, telemedicine minimizes driving time and gives them closer access to specialty care. For subscribers and customers, including critical access hospitals (CAHs) and smaller health systems and clinics, telemedicine gives their patients access to specialists and acute care closer to home, keeping the revenue, whenever possible, at the rural facility. This proximity also makes a difference in patient care and support. “Patients and families typically like to be managed close to home so family members can visit and don’t have to take off work and travel to a distant hospital to be near the patient during hospitalization,” says Dr. Rhone. “It also helps the local hospital to keep that patient local, and the revenue stays with the hospital. This helps to keep CAHs open and successful.”

Avera eCARE offers 24/7 backup for clinicians—an important advantage to physicians considering rural practice, where many times if a physician is not working, they’re on call. Dr. Rhone tells physicians her success stories. “We make a difference in someone’s care every day. I can give examples of how a remote team can really help their patients obtain better outcomes and improve their own work-life balance. We have multiple remote providers who have told their administrators they would not practice in a rural setting without eEmergency as a backup.” Subscribers are finding they are better able to attract physicians to rural areas.

**Webside or bedside?**
Many of Avera’s hub physicians also do bedside medicine. Dr. Rhone enjoys the in-person contact with the patient and feels it’s important for the team on the other side of the call to know she understands what they’re going through. “As an emergency physician, my practice is procedure-oriented. So for me, I feel like I can’t do my telemedicine job if I don’t keep up my skills at the bedside.”

But are standards of care affected when the patient and clinicians are not all in the same room? “The standards of care are not different, because telemedicine is still the same practice of medicine, it’s just that we’re using audio-video technology to accomplish that,” says Tammy Hatting, director of innovation. “However, when it comes to adding telemedicine into a practice, there are standards around how we use telemedicine, or what type of equipment we use for telemedicine.”

**Keeping up with technology**
As part of their subscription services, customers are set up with audio-visual equipment, plus other tools to help with patient examination and diagnosis. Common technology includes handheld cameras, dermatology cameras, stethoscopes, and video laryngoscopes—tools that can be used at the remote site that send data and images directly to the hub. If the clinician has not been trained on any of the equipment, someone from the hub is right there to walk them through the procedure.

“As an emergency physician, one of the most critical procedures we perform is an emergency endotracheal intubation, or an emergency airway,” explains Dr. Rhone. “We now have the ability to attach a cord to a video laryngoscope and see exactly what the remote provider is seeing within a patient’s airway. This is extremely helpful so I can guide their hand with my voice to successfully breathe for a patient.”

**What’s next**
Avera eCARE continues to grow, planning new services for behavioral health, obstetrics and gynecology, and assisted living, plus a new hospitalist program. Their new Virtual Clinic will bring much-needed access to care on Native American reservations in South Dakota, North Dakota and Nebraska.

Despite abundant challenges—the need to maintain state-of-the-art technology, to obtain seemingly endless licenses and credentials, to connect safely with various EHRs and manage other IT challenges—Avera’s telemedicine plans are full speed ahead.
When Hutchinson Health delivers health care through telemedicine, it takes special care to provide the webpage touches that create a local, familiar experience—even if the medical expertise is thousands of miles away. Hutchinson, MN, is a town of roughly 15,000, but its hospital and clinic system serve an area of up to 40,000 people.

Hutch Health, as it’s often called, makes an effort to help keep their patients’ care local. The nearest major hospital is more than 50 miles away, and they know a long trip to see a specialist in a big city, or to visit a loved one in the hospital, can mean missing work or finding others to care for animals or crops. And, of course, additional traveling and arrangements can provoke the kind of additional stress and anxiety that is not conducive to good outcomes.

The primary and longest-standing telemedicine service at Hutch Health is eICU, which they purchase on a subscription basis. “We have two rooms set up with cameras that connect to Avera in Sioux Falls, SD,” says Jim Lyons, chief of clinic operations. “We purchase the service from them, and all their eICU physicians and nurses are on our medical staff. They’re privileged and credentialed here. They’re on our electronic health records system, all our monitors are connected with them, and we also have video and audio in those rooms. We use that service because it gives us access to the eICU intensivists. It brings another level of expertise to the table, and it supports our hospitalist.”

Hutch Health also uses a tele-stroke service that helps benefit both the hospital and the patient. Lyons explains, “When a patient we believe is having or has had a stroke comes into the emergency room, we connect with a specialist. (Our) ER physician and ER nurse work with that specialist to facilitate the physical exam and determine appropriate care for the patient.”

Through telemedicine, the Hutchinson physicians are learning to diagnose and treat conditions they don’t see as often in a rural setting, and the patient gets to stay close so their family can better support them. “If we’re able to care for someone here, and not have to transfer them, it also saves a lot of resources that would be needed for a transfer, whether that’s by helicopter or ambulance,” adds Lyons.

Lyons says that Hutchinson Health will continue to evaluate ways to use telemedicine. The bottom line is this: It needs to add value for the patients and for the community.

LIZ LACEY-GOTZ
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While provider-to-patient telemedicine may have established a role in managing certain acute conditions, it hasn't often been considered a good tool for primary care. But that's about to change, as Sanford Health embarks on an impressive program to offer patients telemedicine options for their primary care, including management of chronic conditions.

Sanford Health is an integrated health system headquartered in the Dakotas, with 45 hospitals and nearly 300 clinics in nine states. With their largely rural patient population, telemedicine has been an effective tool to increase access to care and also a way to keep care local. “Ultimately, we want patients to receive care as close to home as possible,” says Allison Suttle, MD, chief medical officer. “But we also want to provide the same quality of care as if they were in person.”

Currently we’re doing e-visits and video visits only for acute care, something you might go in to urgent care for,” explains Dr. Suttle. “We’re planning this year to expand so that all of our primary care physicians do video visits for their patients. A patient may choose to do a video visit instead of coming in person for a follow-up diabetes evaluation, where no physical exam is needed.” More frequent follow-up visits could allow for more discussion and consultation, helping clinicians check in with patients on their diet, their exercise plan or their recent lab results.

Beyond convenience, video visits would allow opportunities to better manage care, avoid emergencies and allow for a deeper relationship with their primary care team. “We’ve moved a lot to team-based care, so it’s not just the physician. It’s the physician with a pharmacist, with a nutritionist, a behavioral health specialist, a nurse practitioner—so that whole team needs to start using telemedicine as a tool to help take care of their patient,” says Dr. Suttle.

Video visits also provide an opportunity to increase touchpoints with the patient, because they’re not only more convenient but much more efficient than an office visit, with its high overhead. “When we start thinking about managing and taking care of patients and their illnesses, when we see them only in bricks and mortar—for diabetics, for example—we might only see them for one hour out of a whole year,” explains Dr. Suttle. “With video visits, maybe we can see them for 12 hours out of a year. We could have a dietician spend an hour with the patient in consultation, and we could have a health coach work with the patient. Potentially, we can touch the patient more and have more comprehensive care, but ultimately not have it cost the patient all the time to come into the clinic.”

Sanford sees primary care telemedicine as a way to create better outcomes and higher levels of engagement for their patients. And, because of the efficiencies telemedicine can provide, they also expect to realize lower costs and less time spent, for patient and provider alike.
Standard of Care

Thinking through risk management in provider-to-patient telemedicine.

By Emily Clegg, JD, MBA, CPHRM
As a risk consultant with UMIA, I often hear from policyholders who are considering diving into provider-to-patient telemedicine. Provider to patient is the type of telemedicine in which a patient who is in their own home or work space sees a provider with whom they have an established relationship.

For our policyholders, telemedicine presents an opportunity to reach patients in remote areas at more convenient times. Many patients are asking for this new way to connect; however, new health care delivery methods may bring new issues in the event of a malpractice claim.

A malpractice lawsuit involves asking: What was the standard of care? The standard of care is generally defined as the level of care a reasonable clinician with similar training would have given this patient. The plaintiff has to prove—through experts—what the standard of care required, and that the defendant breached or failed to meet that standard of care. As telemedicine brings new ways to connect with and care for patients, it’s prudent to ask: Does a new delivery method for care mean there’s also a new standard of care?

As the medical and legal worlds address this question, the answer is unanimous: Clinicians seeing patients, consulting, prescribing medications or recommending care through telemedicine are held to the same standard of care as they would be at traditional in-person visits. There will not be a lighter or scaled-down standard of care for a telemedicine encounter.

The AMA cautions that the fundamental duties of care do not change with emerging technology. The Federation of State Medical Boards states that traditional standards apply even with flexible models of care. State legislators are putting that standard into law. In many states, like Utah, telemedicine laws include language about the same standard of care as traditional settings.

Considerations for meeting the standard of care

Many practices are meeting the standard of care online in provider-to-patient models, and they’re doing it well. Practices like urgent care, family medicine, dermatology, and behavioral health are seeing success, but it takes some thoughtfulness. To ensure your telemedicine practice is up to the task, here are four considerations:

1. **Can you treat this condition using telemedicine?**

   When considering a telemedicine program, start by considering the right conditions for treatment via telemedicine as opposed to in the office. Said differently, can you care for this issue as well with telemedicine as you could with eyes-on and hands-on care?

   Presently, there is no legal standard for what should or shouldn’t be managed via telemedicine. Clinicians must use their professional judgment. No health care professional should forget the advantages of an in-person visit. Some conditions need in-person care, while others can easily be assessed remotely.

   The American Telemedicine Association gives some guidance in its “ATA Practice Guidelines for Live, On Demand Primary and Urgent Care.”1 Acute conditions appropriate for urgent telemedicine care may include upper respiratory infections, low back pain or skin rashes. Chronic conditions appropriate
**Webside manner** is a term emerging to describe how clinicians show professionalism, competence and empathy over a device screen.

For primary telemedicine care may include diabetes, mental health issues or chronic obstructive pulmonary disease.

Remember, however, that whether a condition is appropriate for telemedicine is determined case-by-case with your professional judgment. If you, as a clinician, believe a condition needs eyes-on and hands-on care, trust your instinct above any guidelines.

2. **Can you care for this patient using telemedicine?**
   The next consideration is whether this patient is appropriate for a telemedicine visit. Connecting online may take away the formality of an in-office visit, but it does not take away the clinician-patient relationship and its corresponding duties and responsibilities. Taking on a patient has legal implications, such as when you have a duty to continue treating or to follow up, when you can be sued for malpractice or when you have “abandoned” a patient. All of these are still true when you connect over a device’s screen.

   One question for patient selection is whether you can communicate effectively. Language barriers, hearing difficulties or even just poor communication skills will be exacerbated over electronic devices. You may not hear nuances of language or pick up on nonverbal cues as well as you could in person.

   As you set up your practice, it’s important to look at the new processes and work flows needed to deliver health care services to patients through telemedicine.

3. **Is the telemedicine environment adequate for me to give good care?**
   Consider whether the physical environment would have the same level of quality it would in person. At an in-person visit, you would have good lighting, a quiet, private space to talk and hear one another, and minimal interruptions.

   Another issue is whether you need access to peripheral tools that an in-person visit would afford. In a clinic or hospital setting, you would likely have access to a throat swab, blood pressure machine, EKG, MRI, labs, pharmaceuticals, etc. If you need those in order to address this condition, then this patient needs to be seen in person. Peripheral tools may also include easy access to medical records. An in-person practitioner may have quick access to prior records before making decisions and recommending treatment. If you would rely on those to make a diagnosis and give recommendations, then you need to duplicate that same secure access to records in your telemedicine practice.

   Privacy is also an essential aspect of care. An in-person visit would likely be in a private room—or at least a private space—where health information is protected. Virtual visits should be private as well, meaning you aren’t at a coffee shop or on the back patio with kids. The patient should also be in a private space. If your patient calls from a crowded bus, perhaps they should call later or head to an urgent care clinic.

4. **Is your webside manner as good as your in-person care?**
   One last consideration is professionalism. Webside manner is a term emerging to describe how clinicians show professionalism, competence and empathy over a device screen. Think through how you’re presenting yourself with this more casual method.

   The clinician-patient relationship is significant. It involves mutual trust and confidence with patients who ask you to guide them through an issue. Dress professionally, wear a visible nametag, sit in front of a plain background and add extra light to your face. Make sure the patient’s impression of you and your environment is one of professionalism and trustworthiness.

   Also be cognizant of your communication skills. Make eye contact, introduce yourself and use the patient’s name. Explain to the patient beforehand if you need to go off screen or look away, such as when filling out or reviewing medical records.

   End each visit by talking through the plan of care. Ensure that you and the patient have mutual expectations about the plan, including any follow-up. Good webside manner gives your patient trust and confidence in you, and also trust and confidence in the plan for their care.

**Making the decision**

Telemedicine is not for every patient, and it’s not for every practice. There are certain patients and conditions where telemedicine may never be able to meet the in-person standard of care. Sometimes eyes-on and hands-on care is best.

Telemedicine can be done, however, and it can be done well. If you choose to dive in, make sure you give careful thought to the standard of care. Make sure you’re comfortable caring for this patient, with this condition, in this environment.

**Reference**


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Telemedicine Risk Checklist

Licensing and Credentialing
☐ Are you licensed in the state where the patient is located?
☐ Are there local prescribing rules you need to follow?
☐ Are you using nursing staff, PAs, NPs, or others who also need to be licensed?
☐ Is there a credentialing process in place?

Clinician-Patient Relationship
☐ Are you creating a clinician-patient relationship?
☐ If not, is that clear to the patient?

Standard of Care—Patient/Condition Selection
☐ Are you providing the same standard of care that you would in person?
☐ Is this patient suitable for care through telemedicine?
☐ Is this condition appropriate for care through telemedicine?
☐ Do you have a plan for an emergency situation?

Physical Environment
☐ Do you have the same ability to communicate and understand as if this patient were in person?
☐ Is the lighting adequate on both sides of the interaction?
☐ Is the video and sound quality adequate?
☐ Can you ensure there will be no interruptions?
☐ Are you comfortable with the reliability of the technology?

Webside Manner
☐ Are you introducing yourself?
☐ Are you making eye contact?
☐ Are you presenting yourself professionally?
☐ Are you showing empathy and compassion on a screen?

Privacy and Security
☐ Are you compliant with HIPAA?
☐ Are you protecting the confidentiality, integrity and security of health information?
☐ Do you have contractual assurances and/or Business Associate Agreements with vendors?
☐ Do you have adequate encryption, passwords, anti-virus, and security software?
☐ Where are your records stored?
☐ Who owns your records if there is a breach?
☐ Are you aware of all the modalities and devices involved?

Patient Safety
☐ Is your patient in a safe, private place to talk?
☐ Do you have concerns about other people nearby?
☐ Could you be missing abuse situations?
☐ Are you refusing to perform intimate exams over video?

Medical Records
☐ How does your e-visit information get into the medical record?
☐ Are you documenting as much as you would in person?
☐ Are you documenting the mode of service and technical information?
☐ Are you documenting any technical problems?
☐ How do your patients request access to records?

Billing
☐ Have you verified that you can bill for this service?
☐ Has your patient verified that their insurance will cover this service?

Professional Liability Coverage
☐ Does your professional liability policy cover telemedicine? (more on page 21)
☐ Does it matter where your patient is located?
☐ Do you need additional cyber liability coverage?

Informed Consent
☐ Are you talking with patients about the risks and limitations of telemedicine?
☐ Are you sharing contingency plans for outages?
☐ Are you managing expectations about what can be accomplished remotely?

Administrative Considerations
☐ Do you have acceptable policies and procedures covering telemedicine care?
☐ Do you have protocols for patient/condition selection and escalation of care?
☐ Are you tracking orders and follow-up plans?
☐ Do you have protocols for record-keeping?
☐ Are you ensuring licensure for each clinician in each state?
☐ Are you ensuring appropriate billing?
☐ Do you have a plan for quality tracking for telemedicine encounters?
☐ Are you assessing patient and clinician satisfaction?
☐ Are you comfortable with clinician competence to use telemedicine?
When Tressa Keller, HIT director and compliance officer at Marias Medical Center, was put in charge of telemedicine technology at the Shelby, MT, hospital where she works, little did she know that she would soon be using it as a patient. “I injured my back while playing softball one night in a local league. When I was admitted to the emergency room, I basically couldn’t walk at all,” Keller remembers. “I had no control over my lower body. I was in excruciating pain.” A CAT scan and lots of deliberation among members of Keller’s care team ensued. Finally, the director of nursing suggested using the hospital’s telemedicine stroke unit to contact a neurologist at Kalispell Regional Hospital. As Julia Drishinski, director of risk management and infection prevention at Marias Medical Center recalls, “How great was it that we could just immediately contact our neurologist, roll the telemedicine unit into the room, and actually consult with the neurologist right then and there.”

And that’s just what they did. After the consult, Keller was flown from Shelby to Kalispell, a three-hour drive by car. A year-and-a-half of follow-up appointments later, she is back to normal.

For people living in states comprised mostly of remote and rural areas, telemedicine is indispensable. Geographic barriers bring added costs of time, transportation and missed work. But when a life is at stake and time is of the essence, telemedicine is how patients get the care they need when they need it. The nearest regional facility could be many hours away by car. The town of Shelby, for instance, is in a distant part of north-central Montana. As Keller remarks, “We’re closer to Canada than we are to the next biggest health system!”

Montana is ahead of the national curve when it comes to widely implemented telemedicine—that goes for program development, infrastructure, technology and legislative climate. How did a state averaging only 6.8 residents per square mile rise to the health care challenge of the future?

**Early vision and resourcefulness**

“Telemedicine developed out of necessity. For patients living in the rural parts of Montana, I can’t think of anything I would like less than to have to jump in my car and go to a follow-up appointment 150 miles away,” says Terry Preite, president of Benefis Spectrum Medical. “Telemedicine was naturally born in Montana because of that rurality.” And because critical access hospitals don’t have the ability to recruit the specialists that a large tertiary center would have, telemedicine plays an essential role in extending access to specialty care in rural states.

Montana’s four major telehealth networks were established in the mid-to-late 1990s. When federal grants became available for rural telemedicine projects, the networks, sponsored by their respective health systems, were ready to grow. In Montana, the broader term telehealth, inclusive of other services such as education, is prevalent throughout the state.

When a life is at stake and time is of the essence, telemedicine is how rural patients get the care they need when they need it.
In addition to the clinical practice of telemedicine, education has been an important remote offering for practitioners and patients alike.

Marias Medical Center is a satellite location of the REACH Montana Telehealth Network, one of the four original networks. Sponsored by Benefis Health System in Great Falls, REACH is a consortium of 14 hospitals and clinics spanning the central and north-central counties, most of which are large and remote.\(^1\)

Like the other major networks, REACH operates on a hub-and-spoke model, which is when a health care facility where the patient is located (the originating site) connects the patient to a health care provider at another facility (the distant site).\(^2\)

“Montana is ahead in connectivity,” asserts Bob Wolverton, program director at the Northwest Regional Telehealth Resource Center (NRTRC), which covers seven states: Alaska, Idaho, Montana, Oregon, Utah, Washington and Wyoming. “Every critical access hospital in Montana is connected to a telehealth network,” he says. The networks also connect patients to specialty services in hospitals outside the state.

Funding, of course, is key to implementing telemedicine technology and infrastructure. U.S. Senator Max Baucus (Montana) championed the use of telemedicine during his tenure in Congress, and was instrumental in securing grant funds for several of the networks, according to Wolverton. Montana’s networks have operated with the support of grants from federal agencies intended to establish telemedicine at critical access sites, including implementing high-speed networks, health information technology systems, EHR systems, and hospital-grade technical hardware.\(^3\)

In addition, the Montana state legislature has been supportive of telehealth. “The legislature recently passed a reimbursement bill that requires private payers to reimburse for telehealth services if they would reimburse for those services in person, which means it requires reimbursement for store-and-forward telehealth, a very rare requirement in the United States today,” Wolverton says. “State law also requires reimbursement for physical, occupational, and speech therapy—again, a somewhat rare requirement. Legislators have shown a great interest in expanding care to underserved populations and continue to support forward-looking legislation.” The legislature has also approved Montana’s participation in the Federation of State Medical Boards’ Interstate Licensure Compact, paving the way for licensure of out-of-state physicians who want to practice telemedicine in Montana.

The Montana state legislature has been supportive of telehealth

On the horizon

What’s on the horizon for telemedicine in Montana? Small hospitals like Marias Medical Center are looking to expand programs and to continue to seek grant funding. Even adding new providers takes time and diligence. “You have to set up each provider individually, and each specialty service separately,” says Julie Drishinski. “And, of course, they have to have compatible equipment on the other side.”

The big picture for small hospitals is that they’re ready and willing to develop telemedicine services to benefit the communities they serve, but are short on physicians. “As programs develop,” Drishinski says, “we need physicians who are willing to provide services via telemedicine. It’s the provider’s choice whether or not they feel comfortable to do that. We need providers who are willing to take that step.”

Gene Koppy, telehealth network administrator for REACH, agrees that provider capacity is a huge issue. “The difficulty in Montana is that there aren’t enough providers in person or via televideo to be able to fulfill the need.” However, Koppy relates, since the interstate compact is already in place, telehealth networks are hopeful that providers will look into the process of getting a Montana license.

On the funding side, the grant opportunities have become treatment specific, according to Koppy. “There isn’t really the grant landscape anymore to start a televideo network from scratch. That sustainability comes from delivering services now,” he explains. “That’s the difference from ten or twenty years ago, when you had that help to be able to build the network, to get it off the ground.”

Small hospitals like Marias Medical Center also need grants to be able to keep up with technology and new modalities arriving on the scene. “We definitely need grants to help small facilities purchase telemedicine equipment and train staff, because we manage month-to-month sometimes, just to keep these small critical access facilities open,” Keller says. “You can see how telemedicine in any way, shape or form will benefit rural patients and their access to a higher level of care. Not to mention the benefit to our local providers, who have to make decisions without a specialist just down the hall.”

Montana patients who use telemedicine services have reason to be grateful: State administrators and policymakers not only had the foresight to develop their networks and infrastructure, but they continue to look for new ways to serve their communities.

References

Are You Covered?
A look at liability insurance for telemedicine.

By Amy Wolf, CPCU

When delving into the world of telemedicine, health care providers have a lot to consider, not the least of which is medical professional liability insurance. While some insurance carriers, including MMIC, UMIA and Arkansas Mutual, are open to insuring telemedicine, others continue to restrict and place limitations on telemedicine-delivered services. The parties involved in a telemedicine arrangement should ensure that a professional liability insurance policy is in place and that it actually affords coverage for the types of health care services performed through telemedicine. A careful review of the policy is warranted. Most importantly, health care providers should contact their insurance agent or insurance company representative in order to verify proper coverage is in place before telemedicine services are provided.

Here are some things to consider:

| Health care service types. Professional liability policies will include a definition of “professional services” that will typically include patient care and other related services. A read-through of this definition is important to verify the telemedicine services being provided fall within this definition. |
| Coverage territory. Most policies will specify where coverage applies. Both the state where the health care provider is located as well as the states where the patients are located should be included within the coverage territory. |
| Restrictions and/or limitations. Some policies contain limitations that restrict coverage to certain services that may not include telemedicine. A thorough review of the policy for any limiting or restricting provisions is important. |
| Exclusions. Some policies contain a specific exclusion for telemedicine. Insurance carriers are often willing to extend coverage but will need to add an endorsement to the policy to provide coverage. |
| Licensing. The health care provider should obtain proper licensure in the state where they are located as well as the states where the patients are located. Not being properly licensed can affect insurance coverage. |
| Cyber liability. Due to the use of technology to provide medicine, there is an increased risk for privacy and security breaches as well as other technology-related exposures. Securing adequate cyber liability insurance is an important aspect to insuring telemedicine. |

Most insurance policies underwritten by MMIC, UMIA and Arkansas Mutual include worldwide territorial definitions, limited exclusions and restrictions, as well as a robust cyber product. Please contact your insurance agent or company representative to verify proper coverage is in place for your telemedicine plans.
Communication FAIL

Documentation and communication errors with a teleradiologist lead to failure to diagnose a subarachnoid hemorrhage, leaving a 67-year-old woman paralyzed with cognitive impairment.

Facts of case
A family physician (FP) examined a 67-year-old woman with complaints of a sudden-onset, severe headache during the night associated with tingling throughout her whole body. At the office visit the next morning, she complained of dizziness, headache and neck pain when flexing her neck. She denied any past history of headaches. The FP ordered a CT scan that was read by the hospital radiologist as unremarkable. The FP prescribed medication for the headache and dizziness.

The next evening, the woman awoke with a severe headache and then lost consciousness with some jerky movements. Her husband called 911, and the woman was transported to the ED by ambulance. EMS personnel documented four seizures during transport. The ED physician ordered another CT that was done at 12:43 a.m. Because the CT was done after hours, the radiology technician sent the CT from the day before (for comparison), along with the most recent CT—incorrectly dated with the previous day’s date—to a teleradiology group for interpretation.

Because the dates on the CTs were the same, the teleradiologist deleted the most recent CT thinking it was a duplicate and read the first CT as unremarkable. The ED physician then admitted the woman to the ICU for neurological observation and started her on
medication to control the seizures. The next day, the hospital radiologist read and dictated a report on the CT that was done at 12:43 a.m., noting that there was a significant subarachnoid hemorrhage with blood in the interhemispheric fissure, around the circle of Willis and along the tentorium. The radiologist verbally communicated the findings to the FP who ordered her transferred to a tertiary hospital. Twice during transport, she had seizure-like activity and became unresponsive.

Upon arrival at the tertiary hospital, she was taken to surgery for a left frontotemporal craniotomy with evacuation of subdural hematoma and clipping of the left posterior communicating artery aneurysm. Following hospitalization, she was transferred to a rehab facility and then a nursing home with right-sided paralysis and significant cognitive impairment.

Her husband filed a malpractice claim against the FP, the ED physician, the hospital and the teleradiologist, alleging failure to diagnose subarachnoid bleed and improper communication with the teleradiologist.

Disposition of case
The malpractice case was settled against the FP, the ED physician and the hospital.

Patient safety and risk management perspective
The experts who reviewed the case were critical of the FP and ED physicians’ care, noting that given the woman’s symptoms, a lumbar puncture should have been done even with a normal CT. They also stated that the radiology technician mismarked the date on the most recent CT and should not have sent both CTs to the teleradiologist. Both of these failures led to the missed diagnosis. The experts opined that with earlier treatment, the woman’s outcome would have been much improved.

Resources
ACEP: Emergency Telemedicine Section https://www.acep.org/telemedicine/

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Patient safety and risk management tips

Improve diagnosis
✓ Rule out potentially serious causes of symptoms using electronic clinical decision support tools or symptom-based checklists.
✓ Maintain a high state of alertness for patients who return with unresolved or worsening symptoms. Broaden the differential diagnosis list.

Enhance communication
✓ Adequately convey the clinical history to telemedicine specialists.
✓ Enhance communication between providers—primary care, emergency medicine, and telemedicine specialists—using standardized communication processes and tools.
✓ Teleradiology interpretations should be available on a timely basis after completion of the study. In addition, the radiologist should be available by phone for discussion with the treating physician if needed.
✓ Technicians should verify that image and test results accurately reflect the date and time of the exam along with communication of pertinent details. Technicians may add comments that could be useful to a teleradiologist interpreting the images.
✓ Implement a system to communicate with the ordering physician when the final image interpretation indicates a discrepancy from the initial read.
Error in Clinical Judgment Leads to Fall

A skilled nursing care team member leaves a woman unattended for five seconds during a dressing change. She falls, sustains a head injury, and dies.

Facts of case
A 64-year-old woman was transferred to a skilled nursing facility (SNF) following a hospitalization for treatment of peripheral artery disease, uncontrolled diabetes and declining overall health. She was assessed as being a high risk for falls and fall-related injuries due to her deteriorated physical condition, dementia and Coumadin therapy. Fall safety precautions were put in place, including mandating a two-person assist to move from the bed to a wheelchair, placement of the bed in the lowest position, a call light within reach, and a large mat next to the bed to provide a cushion if she fell from the bed. She was known to be “wiggly” during transfers and cares. She fell from her bed several times during the first six months after admission without serious injury.

The woman had open wounds on her arms that required dressing changes. One night at 1:30 a.m., the woman picked open a wound and required a dressing change. The LPN assembled the supplies, raised the bed to waist height, and removed the cushion next to the bed so she could re-dress the wound. The LPN forgot one of the dressing supplies, left the bedside and walked across the room to retrieve it. When the LPN turned around to go back to the bed, she saw the woman climbing out of the bed. The woman fell, hit her head, became unconscious and bled profusely from her nose and forehead. The woman coded, and an ambulance was called. CPR was initiated, but the woman died 45 minutes after the dressing change was started.

The woman’s husband and family filed a malpractice claim against the SNF alleging failure to ensure resident safety and prevent injuries due to a fall.
Disposition of case
The malpractice case was settled against the SNF.

Resident safety and risk management perspective
The experts who reviewed the case were critical of the LPN for leaving the bedside with the resident unattended given her high fall risk and history of falls. The LPN testified she was only away from the bedside for five seconds.

A review of MMIC malpractice claims involving SNFs and assisted and independent senior living residences reveals that the failure to ensure resident safety—primarily falls—is the number one most frequent allegation and the number one most costly. Almost half of all claims (41 percent) involved resident falls and almost half (48 percent) of SNF allegations involved high-severity injuries, with 75 percent of these resulting in death. Top injuries preceding death in an SNF include fractures, arrest, hemorrhage, aspiration and infection. The top contributing factors to resident fall injury claims were errors in clinical judgment related to fall and fall injury prevention (81 percent).

Resources
Links to falls prevention resources can be found on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Long Term Care > Best Practice and Evidence-based Resources > Falls Prevention.

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Patient safety and risk management tips

Assess and analyze your risks
- Assess your risk for resident injury and malpractice claims by completing the MMIC/UMIA self-assessments: Long-term Care, Assisted Living, and Preventing Falls.
- Annually evaluate team member clinical skills, competency in equipment use and documentation compliance.
- Monitor the utilization and compliance of fall risk assessment tools through regular medical record audits.
- Assess assistive and mobility equipment for maintenance and repair issues.
- Analyze your adverse events using NPSF RCA2: Improving Root Cause Analyses and Actions to Prevent Harm, or INTERACT tools to detect causal and contributing factors and identify effective actions to prevent future events.

Educate team members
- Educate and train team members on the causes of falls and fall prevention strategies during orientation and annually thereafter.
- Educate and train team members on critical thinking skills using scenario-based training.

Implement safer care policies and communication processes
- Implement a fall prevention policy and program using MMIC/UMIA falls prevention resources and NNHQI mobility resources.
- Initiate a multifactorial fall risk assessment using a validated tool upon admission. Update quarterly or with any change in medication, environment or condition.
- Individualize fall reduction strategies in the resident’s care plan based on the resident’s fall risk assessment.
- Communicate the plan within the organization and across the continuum of care.
- Discuss realistic fall prevention expectations with residents and families using a shared decision-making and person-centered model such as NNHQI Person-Centered Care.

“Missing: Critical Thinking Skills” discusses how a lack of clinical judgment contributes to injury and malpractice claims in senior living and skilled nursing facilities.
A 76-year-old woman with dementia was admitted to a skilled nursing facility due to debilitation. She had steadily lost weight—15 pounds in five months. She had become fatigued, with slurred speech, and was transferred to the emergency department, where she was diagnosed with sepsis, a urinary tract infection, a softball-sized stool impaction, and dirty, moldy dentures. When implementing the woman’s care plan, care team members did not include weight, meals or bowel movement monitoring. This is an example from MMIC senior living malpractice claims in which the top contributing factor was found to be errors in clinical judgment. The allegation in this woman’s case was improper monitoring of resident physiologic status.

Clinical judgment and critical thinking skills
Clinical judgment refers to one’s ability to respond to a situation that may be unclear or require interpretation. When care team members make appropriate clinical judgments, they are employing both critical thinking and clinical reasoning skills. When these important skills are lacking, residents are at risk for injuries and organizations are at risk for malpractice claims. In fact, in reviewing contributing factors to resident injury and claims in the senior living setting, MMIC found that the top two contributing factors were errors in clinical judgment and failure to follow organizational policies.

What are critical thinking skills? Critical thinking has been described as the art of applying theoretical knowledge to actual, real-life situations. Critical thinking requires foundational knowledge as well as the ability to analyze and evaluate evidence or a situation.

When presented with a problem, critical thinkers consider various perspectives and possible solutions, and then choose the best one. They consider the impact of their decisions, the potential outcomes of their choices, and their own training and limitations. Critical thinkers remember to stop to think about a situation before making a judgment. They’re often described as being resourceful, creative, flexible, good communicators, and as “out-of-the-box” thinkers.

In addition to clinical judgment errors, breakdowns in communication among providers compound the problem, as demonstrated by the case of a 72-year-old woman who was placed in a skilled nursing facility for rehab following a surgery to repair a femur fracture. Orders to remove the woman’s leg brace twice a week for hygiene and skin monitoring were given, but care team members didn’t follow the order because they...
In an analysis of 78 professional liability claims involving skilled nursing, assisted living and independent living facilities asserted from 2010 to 2015, the failure to ensure resident safety—primarily falls—was the number one most frequent allegation and the number one most costly.

The top major allegations were:

#1 Failure to ensure resident safety 50%
#2 Improper management of treatment course 13%
#3 Failure to monitor resident physiological status 8%

Almost half of all claims involve resident falls. In one MMIC claim case, an 80-year-old man with mild Alzheimer’s and a documented risk for falls died after he fell in the shower. The care team member had left him alone to respond to an alarm in a nearby room.

A common thread in injury cases is care team members leaving one resident to care for another. In this case, the care team member focused on the needs of the other resident and co-worker, but didn’t consider the potential outcome for the resident under her care. This fall could have been prevented if the care team member had used appropriate clinical judgement.

Moving forward
The ability to provide quality care in skilled nursing and senior living residences is highly correlated with critical thinking skills. That’s why it’s vital for senior living care team members to develop and apply these essential skills. If resident outcomes are to be improved and medical errors reduced, organizations must develop a culture that fosters critical thinking.

The second part of this 2-part series on critical thinking will discuss how to teach and mentor critical thinking skills to care team members. Look for it in the next issue of Brink, Spring 2018.

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Robert Wachter, MD, has a knack for describing what the digital transformation of health care feels like. Take the adoption of electronic health records by hospitals and doctors’ offices, which he says lagged at about 10 percent five years ago and has since shot up to about 90 percent: “We’ve been like a car stuck in a ditch whose spinning tires suddenly gain purchase, so accustomed to being stuck that we were totally unprepared for that first lurch forward.”

You couldn’t ask for a better guide through the unpredictable terrain Wachter covers in The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age. He’s insightful, sure-footed, even-handed, entertaining and humane. And the story he tells is much more than a tech story. As he says of his subject, for which he interviewed more than 100 people, “it’s a story about clinical medicine, ethics, history, sociology, people, policy, politics, psychology, and money.”

A brisk opening section sets out the rationale and impetus for the wiring of health care. Wachter then explores the evolution of the venerable physician’s note into today’s comprehensive electronic medical record, which he describes as “force-fed like a French goose,” swollen with proliferating clinical, imaging, laboratory and other data. Wachter deplores the lack of user-centered design in EHRs and fantasizes about a special field he would add to the medical record, whose mouse-over instructions would exhort the user to “please tell the many people who are coming to see your patient—nurses, nutritionists, social workers, consultants, your attending—what the hell is going on. … Use this section to be more synthetic, more novelistic, more imaginative, more expansive. Tell a story.”

Telling a story is something Wachter does well. One riveting section in the book explores, at length, an EHR-involved medication error that took place at his own institution (UCSF Medical Center). Scene by scene, he reveals how a 16-year-old patient came to be given a 39-fold overdose of a common antibiotic. While the patient appears to have survived the error without adverse impact, and though Wachter recounts the event with great sensitivity, the story is a chilling illustration of how, he says, “many errors pick up a perverse kind of momentum as they breach successive layers of protection.”

Other chapters in the book explore the digital transformation’s effect on doctor-patient relationships, and how movements toward greater transparency, such as OpenNotes, which gives patients electronic access to their medical records, can both improve those relationships and increase patient safety. A section titled “The Players and the Policies” looks more closely at the impact of Meaningful Use, the challenges of interoperability, and the role of EHR vendors such as Epic and athenahealth.

In the book’s final section, “Toward a Brighter Future,” Wachter sketches a future that feels both exciting and attainable. He foresees a time when “intelligent algorithms and automatic data entry will allow each health care professional to practice far closer to the top of their license. As less time is wasted on documenting the care, doctors and nurses will have more direct contact with patients and families, restoring much of the joy in practice that has been eroding like a coral reef, with each new wave of nonclinical demands.” That’s a future worth working toward.
For me, these interactions seemed normal—a natural evolution of patient care made possible by the availability of the telephone. The conversations were typically sufficient to communicate what needed to be communicated. Looking back, I believe I was witnessing the embryonic phase of telemedicine. In the intervening years, it’s no surprise that, as technology has evolved and created more opportunities—for clinicians and patients alike—the number of us seeking care and advice from a distance has grown exponentially.

As one who practiced emergency medicine in a rural setting, often as the lone doc in the “house” on a night shift, I was eternally grateful for the ability to send and receive EKGs and other medical records and data from locations far and wide, and for the willingness of my mentors in emergency medicine at HCMC, where I trained, to confer with me on difficult or perplexing cases. Later, with the development of teleradiology, I could get real-time “wet reads,” which were of tremendous value in managing my patients’ care.

Today, clinicians can see people for urgent care visits, monitor fetal heart rates, guide intubations, perform mental health assessments, and execute delicate robot-assisted surgeries—all virtually! And the possibilities for remote care and consultation grow. Telemedicine is clearly a significant evolving model of care, able to grant access to medical expertise at a time when limited access—geographic, financial, and otherwise—and clinician shortages are growing concerns in health care, in the United States and beyond.

With so much to be hopeful about, it’s important to also acknowledge the risks associated with telemedicine. I recall one such experience from my (and telemedicine’s) early days. A middle-aged woman appeared in our ED with a painful sore throat. Painful, but not red—an important clue that emergency medicine folks are trained to recognize as a mandate to look further. She’d sought help earlier at an outlying facility, where the person who examined her had shined a light onto her posterior pharynx and transmitted the image in real time to a consulting doc at the telemedicine hub that served the facility. Whether due to poor imaging equipment, or a failure to appreciate the significance of a non-red sore throat, this important diagnostic clue wasn’t pursued. Our team correctly diagnosed a life-threatening case of epiglottitis. We were able to get her the help she needed in time, despite the significant delay in diagnosis, but the ease with which her situation could have become a needless tragedy made a lasting impression on me.

As your medical professional liability providers, we encourage you to consider both the advantages and the risks inherent in telemedicine technologies, and practice with an awareness of both. We hope our telemedicine issue is educational and thought-provoking. If you have thoughts or concerns about the topic that you’d like to share, please feel free to reach out to me or anyone on our team. We’re here in service to you.

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Telemedicine at the supper table and in the ER
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DECEMBER

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RETHINKING PAIN MANAGEMENT FOR COMMUNITY HEALTH AND SAFETY
Presenter: Lori Atkinson, RN, BSN, CPHRM, CPPS, MMIC Manager, Research and Education

FEBRUARY

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TRANSGENDER HEALTH
Presenter: Kristin Keglovitz Baker, PA-C, AAHIVS, FCHCLD, Chief Operating Officer, Howard Brown Health Center

JANUARY

10
EVOLVING MODELS OF CARE: EIGHT QUESTIONS TO ASK BEFORE DIVING INTO TELEMEDICINE
Presenter: Emily Clegg, JD, MBA, CPHRM, UMIA Manager and Senior Consultant

MARCH

14
DEVELOPING CRITICAL THINKING SKILLS IN SENIOR LIVING COMMUNITIES
Presenter: Michelle Kinneer, RN, MSN, JD, CPHRM, CHPC, CHC, MMIC Senior Risk and Patient Safety Consultant

NATIONAL WEBINAR
On February 15, Lynne Evans, RN, MSN, CPHRM, will present the ASHRM webinar “PRESCRIBING PRACTICES: ELIMINATING VENDOR VISITS AND SAMPLES IN THE OUTPATIENT SETTING.” Register at ASHRM.org

SPEAKING ENGAGEMENTS
On December 7, Constellation CMO Laurie Drill-Mellum, MD, MPH, will speak on “RECLAIMING THE JOY IN MEDICINE: PERSONAL PRACTICES AND SYSTEMIC APPROACHES” at Bounce Back’s Resilience Conference 2017: Moving from Surviving to Thriving at Crowne Plaza in Plymouth, MN. Register at bit.ly/2zsyiXy

On February 7, MMIC Senior Patient Safety Consultant Kristi Eldredge, RN, JD, CPHRM, will present “BEST PRACTICES FOR SOCIAL MEDIA IN THE LTC ENVIRONMENT: FACEBOOK, TWITTER AND SNAPCHAT... OH MY!” at the LeadingAge Minnesota Institute expo at RiverCentre in St. Paul, MN. Register at bit.ly/2znqkdz